(1) The number of trainees enrolled in nationally accredited graduate medical education programs. Full time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

(2) The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

c. A service index which comprises three components:

(1) The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as reported on the Agency for Health Care Administration Worksheet A-2, located in the Budget Review Section of the Division of Health Policy and Cost Control for the last fiscal year reported to the agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Service Index values where the total is computed for all state statutory teaching hospitals;

(2) Volume-weighted service index, computed by applying the standard Service Inventory Scores established by AHCA under 409.9113 F.S., to the volume of each service, expressed in terms of the standard units of measure reported on the Agency for Health Care Administration Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals;

(3) Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital

represents of the total of such Medicaid payments, where the total is computed for all statutory teaching hospitals.

3. The following formula shall be utilized by the department to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP =THAF x A

Where:

TAP =total additional payment.

THAF =teaching hospital allocation factor.

A =amount appropriated for a teaching hospital disproportionate share program. (as found in Appendix B)

D. Mental Health Disproportionate Share Payments

The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the mental health disproportionate share program:

$$TAP = \left(\frac{DSH}{TDSH}\right) X\ TA$$

Where:

TAP =total additional payment for a mental health hospital

DSH =total amount earned by a mental health hospital under s. 409.911

TDSH =sum of total amount earned by each hospital that participates in the mental health hospital disproportionate share program

TA =total appropriation for the mental health disproportionate share program. (as found in Appendix B)

In order to receive payments under this section, a hospital must participate in the Florida Title XIX program and must:

a. Agree to serve all individuals referred by the agency who require inpatient psychiatric services, regardless of ability to pay.

b. Be certified or certifiable to be a provider of Title XVIII services.

c. Receive all of its inpatient clients from admissions governed by the Baker Act as specified in chapter 394.

E. Determination of Rural Hospital Disproportionate Share/financial assistance program. In order to receive payments under this section, a hospital must be a rural hospital as defined in s. 395.602, Florida Statutes, and must meet the following additional requirements:

a. Agree to conform to all agency requirements to ensure high quality in the provision of services, including criteria adopted by agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the agency deems appropriate as specified by rule.

b. Agree to accept all patients, regardless of ability to pay, on a functional space-available basis.

c. Agree to provide backup and referral services to the county public health units and other low-income providers within the hospital's service area, including the development of written agreements between these organizations and the hospital.

d. For any hospital owned by a county government that is leased to a management company, agree to submit on a quarterly basis a report to the agency, in a format specified by the agency, which provides a specific accounting of how all funds dispersed under this act are spent.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the rural hospital disproportionate share program or the financial assistance program:

TAERH =(CCD +MDD)/TPD

Where:

CCD =total charity care-other, plus charity care-Hill Burton, minus 50 percent of unrestricted tax revenue from local governments, and restricted funds for indigent care, divided by gross revenue per adjusted patient day; however, if CCD is less than zero, then zero shall be used for CCD

MDD =Medicaid inpatient days plus Medicaid HMO inpatient days.

TPD =total inpatient days.

TAERH =total amount earned by each rural hospital

In computing the total amount earned by each rural hospital, the agency must use the average of the three (3) most recent years of actual data reported in accordance with s.408.061(4)(a), Florida Statutes. The agency shall provide a preliminary estimate of the payments under the rural disproportionate share and financial assistance programs to the rural hospitals by August 31 of each state fiscal year for review. Each rural hospital shall have 30 days to review the preliminary estimates of payments and report any errors to the agency. The agency shall make any corrections deemed necessary and compute the rural disproportionate share and financial assistance program payments.

STATE Florida DATE REC'D 6/3/04 DATE APPV'D 6/21/04 DATE EFF 5/1/04 HCFA 179	A

(a) In determining the payment amount for each rural hospital under this section, the agency shall first allocate all available state funds by the following formula:

DAER =(TAERH x TARH)/STAERH

Where:

DAER =distribution amount for each rural hospital.

STAERH =sum of total amount earned by each rural hospital.

TAERH =total amount earned by each rural hospital.

TARH =total amount appropriated or distributed under this section. (as found in Appendix B)

Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share payments under this section.

(b) For state fiscal year 1996-97 and subsequent years, the following steps shall be used to determine the rural disproportionate share payment amount for each hospital.

(1) The agency shall first determine a preliminary payment amount for each rural hospital by allocating all available state funds using the following formula.

PDAER=(TAERH x TARH)/STAERH

Where:

PDAER =preliminary distribution amount for each rural hospital.

TAERH =total amount earned by each rural hospital.

TARH =total amount appropriated or distributed under this section.

STAERH =sum of total amount earned by each rural hospital.

(2) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (E)(1) above.

(3) The state funds only payment amount is then calculated for each hospital using the formula:

SFOER =Maximum value of (1)SFOL - PDAER or (2) 0

Where:

SFOER =state funds only payment amount for each rural hospital

SFOL =state funds only payment level, which is set at 4% of TARH.

(4) The adjusted total amount allocated to the rural disproportionate share program shall then be calculated using the following formula:

ATARH =(TARH - SSFOER)

Where:

ATARH =adjusted total amount appropriated or distributed under this section (as found in Appendix B)

SSFOER =Sum of the state funds only payment amount (E)(3) for all rural hospitals.

(5) The determination of the amount of rural DSH funds is calculated by the following formula:

TDAERH =((TAERH x ATARH)/STAERH)

Where:

TDAERH =total distribution amount for each rural hospital.

(6) Federal matching funds for the disproportionate share program shall then be calculated for those hospitals that qualify for disproportionate share in section (E)(5) above.

(7) State funds only payment amounts (E)(3) are then added to the results of (E)(6) to determine the total distribution amount for each rural hospital.

TDAERH =(TDAERH +SFOER)

F. Determination of Disproportionate Share Payments for Specialty Hospitals

1. The following formula shall be used by the agency to calculate the total amount available for hospitals that participate in the specialty hospital disproportionate share program:

TAE=(MD/TMD) x TA

Where:

TAE=total amount earned by a specialty hospital.

TA=total appropriation for payments to hospitals that qualify under this program. (as found in Appendix B)

MD=total Medicaid days for each qualifying hospital.

TMD=total Medicaid days for all hospitals that qualify under this program.

2. In order to receive payments under this section, a hospital must be licensed

in accordance with part I of chapter 395, participate in the Florida Title XIX program, and meet the following requirements:

a. Be certified or certifiable to be a provider of Title XVIII services.

b. Receive all of its inpatient clients through referrals or admissions from county public health departments, as defined in chapter 154.

c. Require a diagnosis for the control of a communicable disease for all admissions for inpatient treatment.

G. Determination of Primary Care Disproportionate Share Payments

1. Disproportionate Share Hospitals that qualify under VI.A. above for regular disproportionate share hospital payments and meet all of the following requirements shall qualify for payments under the primary care disproportionate share program. For state fiscal year 2002-2003 and 2003-2004 forward, hospitals that qualified and received a payment under this Section will qualify to receive a payment.

a. Agree to cooperate with a Medicaid prepaid health plan, if one exists in the community.

b. Agree to ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

c. Agree to coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level, except that eligibility may be limited to persons who reside within a more limited area, as agreed

to by the agency and the hospital.

d. Agree to contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility, primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

e. Agree to cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

f. Agree to, in cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area.